MEDICAL STATUS FORM

This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer.

Patient/ Employee Info

Patient/Employee Name (Last, First)		Timestamp for Health Care Providers	Clear Form
Date of Injury (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)	Provider Info: Health Care Provider Name & Address	
Date of Next Visit	Claim Administrator Number		

Released for Work?

Please select ONE of the following (Note - Temporary, alternative and full duty return dates are subject to reassessment)

☐ Condition Unchanged from Last Report	
☐ Patient/Employee Released to Full Duty	Effective Date
☐ Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)	Effective Date
☐ Time Loss Authorized - objective findings indicate worker should remain off work	Effective Date
▷ Anticipated date patient/employee can perform temporary alternate work	Anticipated Date
▷ Anticipated date patient/employee can return to full duty	Anticipated Date

Work Abilities for Temporary or Permanent Modified Work
(Please Mark Choices In All Categories)

Total Number of Hours/Day Patient/ Employee May Work:

_____days per week

_____hours per day

Number of Hours										NR = Not Restricted
Sit	0	1	2	3	4	5	6	7	8	NR
Stand	0	1	2	3	4	5	6	7	8	NR
Walk	0	1	2	3	4	5	6	7	8	NR

Patient/Employee ☐Should / ☐Must ☐Sit / ☐Stand / ☐Walk Every _____hours

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
	Example of Category: NEVER equals 0%; OCCASIONALLY equals 1-33%; FREQUENTLY equals 34-66%; CONTINUOUSLY equals 67-100%				
Hand/Wrist Work ☐L☐R☐B	☐	☐	☐	☐	☐
Grasping ☐L☐R☐B	☐	☐	☐	☐	☐
Pushing/Pulling ☐L☐R☐B	☐	☐	☐	☐	☐
Fine Manipulation ☐L☐R☐B	☐	☐	☐	☐	☐
Reaching ☐L☐R☐B	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐	☐

Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? ☐No ☐Yes If Yes, please explain _____

Will the patient/employee be required to use any devices or braces? ☐No ☐Yes If Yes, please explain _____

Additional comments specific to patient/employee's work abilities _____

Can the patient/employee return to work at time of injury occupation? ☐No ☐Yes

Signatures

Patient/Employee Signature	Date
Health Care Provider's Signature	Date

Medical Status Form 9/19/11

This section contains private information for the MEDICAL PROVIDER, INSURER AND PATIENT/EMPLOYEE ONLY and is NOT to be given to EMPLOYER

Diagnosed Condition _____

Treatment plan to increase functional improvement until next appointment _____

Identity of medication prescribed _____

Anticipated MMI date _____ Actual MMI date _____ Perm WP Impairment Rating _____ %

ECONOMIC AFFAIRS IC
October 5, 2011
EXHIBIT 19

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Stand	0	1	2	3	4	5	6	7	8	NR
Walk	0	1	2	3	4	5	6	7	8	NR

Patient/Employee ☐ Should / ☐ Must ☐ Sit / ☐ Stand / ☐ Walk Every _____hours

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
	Example of an eight hour work day, NEVER equals 0%, OCCASIONALLY equals 1% to 33% (1-2.6 hours), FREQUENTLY equals 34% to 66% (2.7-5.2 hours), and CONTINUOUSLY equals 67% to 100% (5.3+ hours)				
Hand/Wrist Work ☐L☐R☐B	☐	☐	☐	☐	☐
Grasping ☐L☐R☐B	☐	☐	☐	☐	☐
Pushing/Pulling ☐L☐R☐B	☐	☐	☐	☐	☐
Fine Manipulation ☐L☐R☐B	☐	☐	☐	☐	☐
Reaching ☐L☐R☐B	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐	☐

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This page is for PATIENT/EMPLOYEE and EMPLOYER